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The bereavement therapeutics and its diagnostic criteria: possible contributions of Tatossian

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Abstract: The DSM-5 enlarge the discussion about the differentiation between normal and complicated bereavement. Based on the work of Arthur Tatossian and on a phenomenological comprehension of bereavement, this article aims to discuss the clinical practice with bereaved patients and its relations to diagnostics issues. We present the concept that mourning is experienced as an intersubjective phenomenon lived as a loss of a shared world, disrupted by death. When someone loses a loved one, he/she also loses a perspective, and an existential possibility, so that the mourner is left with the need to signify his/her existence, which is not a returning to a previous life. Based on Tatossian's proposition of substitutive-dominant and anticipatory-liberatory care, we propose that bereavement therapy should consider the patients' freedom-unfreedom dyad as a criterion for understanding its pathological dimension and for the care the mourner dedicates to its existence.

Keywords: bereavement, clinical practice, psychotherapy, Tatossian.

The fifth and final edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) is indicative of how bereavement is considered and studied nowadays. More specifically, in the chapter "Conditions for further study," the Persistent Complex Bereavement Disorder is addressed as a diagnosis unofficially recognized, requiring further studies. According to the DSM-5 (American Psychiatric Association [APA], 2013), chronological time should be the criterion for the distinction between normal and complicated bereavement. After 12 months (six months, in the case of children) in which a set of persistent symptoms of mourning is manifested, the bereaved person is diagnosed with Persistent Complex Bereavement Disorder. That is, after this period, reactions related to mourning are considered symptoms that would "interfere with the individual's capacity to function" (APA, 2013, p. 792).

The manual organizers mention the need to for researchers and clinicians to conduct more studies in order to achieve a consensus about the inclusion or not of the Persistent Complex Bereavement Disorder in its next editions (APA, 2013). Two critical aspects for understanding bereavement in its pathological dimension refer to the duration of symptoms as well as its differentiation from depressive disorders. One of the most relevant points of the debate becomes precisely the possibility of distinguishing mourning from depression, mainly through the phenomenological description of mourning (Ratcliffe, 2018). The phenomenological description leads to more refined and complex aspects regarding the way lived experiences emerge and are signified, providing bases to clinicians in their diagnostic decision. It is within this context that our study is inserted. We aim to reflect on the models of diagnoses that focus on the comprehension of what is normal and complicated in bereavement from the perspective of phenomenology and to offer possibilities of assistance and care to bereaved people in clinical practice based on the phenomenological proposal of Arthur Tatossian (1929-1995).

The understanding of bereavement in the DSM-5

The creation of the DSM-5, between 2007 and 2012, was followed by debates and controversies regarding the comprehension and classification of bereavement (Zachar, 2015). Among questions raised by the specialists was the need for a more precise differentiation between bereavement and Major Depressive Disorder. In the previous edition of the manual (APA, 1995), bereavement was deemed as an exclusion criterion for the diagnosis of depression, in case the loss has occurred within an interval of up to two months. Hence, at least in this two-month period, the bereaved could not receive the diagnosis of depression. Another point present in the debate was the election of possible criteria to determine what would distinguish a considered "normal" mourning from a "complicated" or "pathological" one (Freitas, 2018).

Until the emergence of the DSM-5, most of the discussions in the academic field addressed if the recent

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loss of a loved one should be an exclusion criterion for Major Depressive Disorder. Among those favorable to the maintenance of the criterion, the argument was that its exclusion could lead to the pathologization of habitual grief reactions, which could lead to the medicalization of bereaved people without a real necessity (Zachar, 2015). Those who defended the removal of bereavement as an exclusion criterion from depression diagnosis, in their turn, questioned why other types of loss, such as relationship breakups or a job resignation, were not included as exclusions criteria for the disorder diagnosis in the DSM-IV (Zachar, 2015). According to them, there are no studies whose authors demonstrate significant differences in symptomatology between a person undiagnosed with depression due to grief and one with depression. The difference, in terms of stressors, would not justify the special treatment given to cases of bereavement, with insufficient arguments for its maintenance as an exclusion criterion in a new edition of the manual (Lamb, Pies, & Zisook, 2010; Zachar, 2015). According to Lamb et al. (2010), this exclusion criterion denies to patients with depression the possibility of receiving the appropriate treatment, and this deprivation of care could lead to profound consequences for the rest of the lives of bereaved people. Zachar (2015) corroborates this argument, defending that bereaved people should have the opportunity to choose treatment if they receive the diagnosis of depression. Those favorable to the removal of mourning as an exclusion criterion for the diagnosis of depression also highlight that this change should not lead to the medicalization of grief since most mourners do not present all the symptoms of Major Depressive Disorder (Lamb et al., 2010; Zachar, 2015).

Concerning the diagnosis of Major Depressive Disorder, the DSM-5 (APA, 2013) organizers decided not to adopt bereavement as an exclusion criterion. The manual also included a phenomenological description of the characteristic reactions of mourning in order to specify what distinguishes it from symptoms consisting in a major depressive episode (MDE), thus facilitating the diagnosis given by the clinician. The DSM-5 (APA, 2013) emphasizes, for example, the fact that "in grief the predominant affect is feelings of emptiness and loss, while in MDE it is persistent depressed mood and the inability to anticipate happiness or pleasure" (p. 161). Moreover, it was highlighted that the dysphoria of grief occurs in waves, commonly called "the pangs of grief". Since this alteration was undertaken in the diagnosis of Major Depressive Disorder, the possibility of the co-occurrence of bereavement and depression is no longer dismissed, and clinicians must be aware to distinguish a possible depression from what would consist only in a normal and adaptive response to loss (Zachar, 2015). By adopting this discernment, clinicians should be cautious when assessing psychosocial aspects of the patients, surpassing the mere listing of symptoms (Ogasawara, Nakamura, Kimura, Aleksic, & Ozaki, 2017).

If the DSM advanced in the direction of a conclusive response into the discussion about the differentiation between bereavement and depression, and on the possibility of the co-occurrence of both, there are still questions regarding the distinction between normal and complicated grief. After all, even when the bereaved do not receive the diagnosis of depression, symptoms characteristic of grief may inflict significant suffering, a condition that may require interventions of healthcare professionals (Lamb et al., 2010). In this perspective, it is worth noting that, as it was in its previous edition, in DSM-5 there is a section about some conditions that should be focused on clinical care, among which we find the Uncomplicated Bereavement. According to the manual (APA, 2013), "this category can be used when the focus of clinical attention is a normal reaction to the death of a loved one" (p. 716). It is noteworthy that the isolated emergence of characteristic symptoms of a major depressive episode, such as insomnia, reduced appetite, weight loss, and depressive mood, usually occurs in bereaved individuals. Although bereavement does not consist in a mental disorder, it unfolds the possibility to bereaved people receive professional assistance in order to relieve such symptoms.

Regarding the creation of a specific diagnosis for complicated bereavement, the fifth edition of the DSM emphasizes the difficulty in establishing what would be the "duration" and the "manifestation" that could be deemed as a reference, due to variations in the experience of mourning within different cultural groups. Stroebe et al. (2000) emphasize that the complexity and multidimensionality of the phenomenon require that a series of investigations and debates precede the creation of a specific diagnostic categorization for complicated bereavement. According to the authors, there are several criteria adopted by different researchers to differentiate normal from pathological grief, without having enough empirical evidence to support the choice of any of these. Among the criteria proposed by specialists, we can mention the duration of mourning, the intensity of symptoms, and functional impairments, among others.

The DSM-5 did not create an official diagnosis for complicated bereavement, pointing to the need for further and in-depth studies, which could score the criteria that circumscribe the pathological bereavement. Not having a structured diagnosis motivated the insertion of a proposal called "Persistent Complex Bereavement Disorder" in a section entitled "Conditions for further study" (APA, 2013). If the proposal were approved, in an upcoming edition of the manual, we would have a specific diagnosis for complicated bereavement, which could draw a clear line to separate healthy from pathological mourning. According to this proposal, normal bereavement would be persistent when particular expected responses to a significant loss lasted for at least 12 months (or six, in children), and, after this period, it would be considered as symptoms of a complicated bereavement (APA, 2013). In other words, the

criterion adopted to such distinction is a specific interval of time. It is worth reflecting on this criterion adopted by the new edition of the manual, as well as its understanding of bereavement as a whole since it disregards other relevant elements in the process of diagnostics such as the historical and singularized perspective of suffering inherent in every mourning. Within this context, in which discussions about a possible new diagnosis involving the condition of bereavement are in vogue, it is important to present contributions that provide this debate a phenomenological perspective of mourning.

Bereavement from a phenomenological perspective

The phenomenological understanding of bereavement, which we shall briefly present next, is based on Merleau-Ponty's (1960/1991) concept of intercorporeity. According to the author, the I and the other are organs of the same intercorporeity. Intercorporeity concerns the intersubjective entanglement between humans and the world, where the alterity is manifested primarily as an aesthetic and sensitive experience. The intercorporeity character of existence is nothing but the condition of the possibility of the subjective experience. That is, ipseity shows itself in the presence of the other, and such does not only reveals itself to me in its difference, but it opens to me a sensitivity of both the world and myself, in the same ambiguous way by which my two hands, when touching each other, are also touched, manifesting themselves as *sameness* and alterity.

Bereavement, from this perspective, can be understood as an experience that begins with the death of a loved one and with the consequent and abrupt deletion of the (inter)corporeity in the bereaved existential field, since, suddenly, that living body the other was, becomes a mere object (Freitas, 2018). The loss of this other, with whom a temporality is shared and with whom the bereaved is sensitively related, is experienced as the loss of a shared life-world (Freitas, Michel, & Zomkowski, 2015). With death, the once shared world changes and fades, a moment in which the bereaved loses a unique and usual way of being, which is proper of the very relationship that has been lost. Therefore, one does not only lose someone, but also a bit of herself and of a world, lose what she *is* in the relationship established and experienced with the lost one. It is from this absence of the other in the lived world that "the experience of mourning emerges, as this novelty, requiring a meaning that places at stake relational specificities, the historical horizon, and the life-world of the bereaved" (Freitas, 2013, p. 99).

Bereavement, therefore, is not a linear process determined by stages or early and final phases, but a new existential condition in which those who have lost a meaningful person are thrown. Mourning as a new existential condition puts on hold the habitual senses of the life-world, demanding new meanings and a new way of being-with the deceased, because, despite not being present as corporeity, the loved one who died is daily present in the world that announces her through habits, shared experiences and objects, but in absence. Thus understood, bereavement can no longer be considered as an individual phenomenon, but as intersubjectively circumscribed: "existentially understanding the process of bereavement is, therefore, about understanding the ways of being that are lived in the experience of a radical and definitive rupture in the life-world of the bereaved in its intersubjective , specifically intercorporeal character" (Freitas, 2018, p. 52). Hence, the bereavement experience is presented as a request for resignification of a shared existence, and not exactly a recovery. There is no possible recovery, in the sense that there is no possible return to a previous world, to a life as shared with the deceased. There only possibility is to signify this relationship from their presence-absence: "mourning cannot be understood as an experience from which we can recover [...] Bereavement, literally, becomes incorporated in existence, thus allowing new possibilities of significations and openness before this very existence" (Freitas, 2018, p. 55).

Another aspect related to a no recovery, but related to its incorporation into existence, points to the experience that the bereavement lived experience is always unfinished and not organized as a continuous flow. Grief is lived by the bereaved as "waves." This description unveils that the pain of grief tends to be experienced anew from time to time, such as on festive dates or at important occasions, when the existential world emerges as a meaning shared with those who have gone. The lived experience described as waves, i.e., the moments of resuming emotions related to the suffering of grief are described in the DSM-5 (APA, 2013) as well as in research on the phenomenological experience of bereavement (Zachar, 2015; Zisook & Shear, 2009). It remains unclear how pain and the absence of meanings are manifested in different existential conditions of bereaved people, particularly, when we have clinical concerns, and not just epistemological ones.

When we question ourselves about the different ways mourning reveals itself in concrete existences, from personal stories and lives, we put at stake the character of what is understood as pathological, since each way of mourning is linked to each way someone lived a specific relationship and to a particular historical condition. Thus, the understanding of the distinction between the normal and the pathological rests on the evaluation of the phenomenological expression of mourning, regarding how bereavement is manifested in the life of those who are grieving, and not by the quantitative mark of what is disclosed. To develop this reflection, we employ the comprehension disclosed by the diagnostic models and their relation to the clinical practice promoted by the work of Tatossian, a psychiatrist who devoted himself to the phenomenological psychopathology and who was one of its leading representatives (Bloc & Moreira, 2014).

Phenomenological psychopathology and the clinical practice conceived by Tatossian

Tatossian understands phenomenological psychopathology as indissociable from the clinical practice. According to the author, there is an intertwining of psychopathology and clinical practice in such a way that it is impossible to delimit their mutual influences (Tatossian, 1979/2006). The clinical practice constitutes psychopathology, precisely because it is where the experience of the subject presents itself. To support the clinical practice is the *raison d'être* of psychopathology. At the same time, psychopathology becomes necessary for clinical practice in its search for understanding the patients living world. The ambiguity in the relationship between these two fields is emphasized throughout the entire work of Tatossian (Bloc, 2012).

By highlighting the lived experience of the patient, "Tatossian approaches phenomenology and psychiatry without constructing a rigid model of both psychopathology and phenomenological clinical practice" (Bloc & Moreira, 2013, p. 38). Operating with the concept of *Lebenswelt*, the psychiatrist disrupts a concept of subject as an individual, and by this mean, he considers that the constitution of psychopathological lived experience is given in the daily life of men. Thus, according to Bloc (2012), the author aims the "constitution of the psychopathological lived experience, but without disregarding what constitutes it, as well as the flow of an experience that is unstoppable and which should be intended by the clinician" (p. 110).

The author more properly discusses clinical practice in his article *What is the clinical practice?* (Tatossian, 1989/2012), in which, from the beginning, he warns the reader this is a question whose answer may be less evident than expected. Tatossian responds to the question in the title by presenting two different models, both constituents of the clinical practice, which are not absolutely independent, namely: the inferential model and the perceptual model.

The inferential model, most commonly accepted in the clinical activity, aims to infer the not directly observable nosological entity, from the directly observable symptom (Tatossian, 1989/2012). According to this model, progress is associated with the development of strict rules of observation and inference, the establishment of criteria and scales for the evaluation of illnesses, as well as delimitation of the characteristics that define each one – which is common to diagnostic manuals such as the DSM-5. Here, the idea of progress is linked to and contaminated by an effort to make the clinical practice more and more "quantitative" (Tatossian, 1989/2012).

According to Tatossian (1997/2014), the inferential model of the clinical practice, by reducing its activity only to semiological relevance, excludes most of the information presented in the direct relationship with the patient. Besides, despite concentrating on the examination of symptoms, it disregards other information presented in the relationship with the patient that guides the clinician's decisions. Such information, neglected by the inferential model, is key to the clinical activity in the perceptual model, which would be fundamentally phenomenological.

Differences between inferential and perceptual models lie in a shift on the professional perspective, which enables a practice not exclusively focused on the symptom, but aware of the *phenomenon*. In the perceptual model, the clinician does not perceive the illness, but the totality of being ill instead. Likewise, the aim is not to analyze the determinant causes of the illness, but to apprehend the essence and conditions of the presentation of the phenomenon in question (Tatossian, 1997/2014). This shift is not easy for psychiatrists, psychologists, or psychotherapists "habituated with representations of natural science, using diagnostic manuals, and proposing treatment models that comprise, mainly, the experience of the symptom" (Bloc, 2012, p. 40).

By focusing on the phenomenon, the perceptual model evidences the autonomy of the patients and their freedom when facing the situation in which they are. After all, if the phenomenon is subjectively constituted and has its meaning unveiled in the existence of those who suffer, patients can never be completely heteronomous, and there will always remain to them an autonomy position (Tatossian, 1997/2014). From a semiological perspective, "the disease is already located in the symptom and in what produces [it], clearly isolating the man, who is nothing but the [its] bearer" (Bloc & Moreira, 2013, p. 34). Based on this discussion of two possible models in the clinical practice, Tatossian evidences the need of establishing a criterion that differs the normal from the pathological without disregarding the subjective constitution of the phenomenon and the autonomy condition that, to some extent, is left to the patients.

Normal or pathological: freedom as a criterion

Tatossian distances himself from the perspective of morbidity that conceives man as its mere bearer. Seeking to perceive not the nosological entity, but the totality of being, the author argues that, according to Bloc (2012), "the pathological is much more related to disempowerment, to the loss of the freedom of the subject than to the establishment of strict rules and parameters" (p. 69). Thus, the author relates freedom to the health-illness issue, considering the differentiation between normal and pathological based on the freedom-unfreedom dyad, and on the dialectical relationship between autonomy and heteronomy.

According to Tatossian's reasoning (2001), the deviant behavior, which does not fit rules and parameters, should not be considered abnormal by itself, nor can be taken as an object of psychopathology. Bloc (2012) argues that deviant behavior becomes abnormal to the extent the subject cannot fail to present it. That is, while autonomy is, to some

extent, preserved and there is the possibility to the subject of not showing deviant behavior, such cannot be regarded as *pathos*. Stagnation, however, would indicate the existence of a behavior pattern that can be considered pathological, from the perspective of crystallization. (Bloc, 2012).

Although Tatossian emphasizes the analysis of the phenomenon, he does not disregard the symptom as relevant for the development of the diagnosis and the choice of clinical conduct. However, the diagnostic plays here an accessory role, being only a signal of the phenomenon (Tatossian, 1997/2014). Changing the focus from the symptom to the phenomenon means a rupture of the symptomatology model usually present in psychiatry. According to Bloc (2012), this shift has impacts on the patient's freedom and, similarly, on the concepts of cure and treatment. After all, if in the psychiatry practice based on symptoms the cure is imposed to the patient in the way of disappearing symptoms, in the psychiatry of the phenomena, this last becomes the leading agent of the process of treatment and comprehension of what is considered as a cure. The emphasis on the phenomenon, therefore, impacts the conception of cure and allows the development of a therapy that can go beyond the pharmacological one, restoring confidence in whom patients are and what they know about themselves.

The phenomenon: principle of Tatossian's psychotherapeutic project

Tatossian (1997/2014) appropriated Heidegger's concept of "solicitude" (Fürsorge), the ontological characteristic of Dasein while being-with or, more accurately, "being-alongside" (Heidegger, 1927/1985) to think about the phenomenon as the foundation of the clinical project. For Heidegger, both solicitude (Fürsorge) and concern (Besorgen) are ontological components of care and, therefore, ways of Dasein´s openness. Moreover, there are two possibilities of solicitude (Fürsorge), namely, a substitutive and an anticipatory. The first one is when someone takes over for the others, "leap in" (Einspringt) for them, and assume their concerns. On the other hand, the second kind of solicitude "leaps ahead" (Vorausspringt) of the other, anticipating oneself before her own possibilities, without replacing them (Heidegger, 1927/1985; Santos & Sá, 2013). Tatossian (1997/2014), when appropriating the Heideggerian concept, prefers replacing the word "solicitude" with "assistance," in order to exclude an affective resonance of the term in French that he did not deem adequate.

When Tatossian (1997/2014) thinks about the clinical management influenced by the comprehension of possibilities opened by solicitude (Fürsorge), he presents and differentiates two positive forms of assistance, namely: substitutive-dominant assistance (substituante-dominante) and the anticipatory-liberatory assistance (dévançante-libérante). The first is a mode of assistance that consists in "leap in" the other, dealing with what the other would have to do by himself. It is a mode of clinical management that removes the other from their place, providing them an immediate and available solution to their problem. The substitutive-dominant assistance happens, for example, when the psychiatrist decides to hospitalize a patient or when, throughout psychotherapy, the psychotherapist provokes preprogrammed changes in the patients' experience independently of their will by applying a technique with a definite purpose, for example. Substitutive-dominant assistance tends to places the other in a position of dependence and subjection.

The second mode of care, which Tatossian (1997/2014) calls in French *dévançante-libérante,* and which Bloc and Moreira (2013) translated to Portuguese into "anticipatory-liberatory" assistance, regards a mode of solicitude that aims to "take the other further, potentializing them in a clinical management that starts from the belief in the potentiality of the other and in the freedom that, in different ways, is always present" (Bloc & Moreira, 2013, p. 36). The anticipatory-liberatory assistance seeks to recognize the other lucid and free, placing them before their possibilities and resuming their self-care.

Tatossian (1997/2014, p. 278) states that these two forms of positive assistance are usually combined successively or simultaneously, according to the circumstances and the clinical condition of the patient. Nevertheless, the author argues that it is essential for patients always to be left with a minimum of freedom. The author also highlights that these two forms of assistance cannot be understood as exclusively associated with specific theoretical techniques or approaches. Any theoretical technique or approach may be a form of substitutive-dominant or anticipatory-liberatory assistance, depending on how such a technique will be applied or whether a particular theory will work. The decisive factor in differentiating the mode of assistance in each case is how much this practice promotes – or not – the recovery of patients autonomy. We shall seek how these modes proposed by Tatossian of positive assistance can be articulated with the psychotherapeutic process of bereaved people and what is the relevance that a project of a clinical practice supported in this phenomenological model may have for the bereavement process.

Discussion: the bereavement therapeutics as care and freedom

From the brief presentation of bereavement in its existential character, as well as the way Tatossian thinks of the clinical practice and psychopathology, we aim to reflect on the phenomenon of mourning and its implications for the different modes of assistance and care. To do so, we resumed the discussion of bereavement understood as complicated, widely medicated nowadays, and which increasingly demands attention from specialized services.

The diagnosis of complicated bereavement or, as presented in the DSM-5 (APA, 2013, p. 789), Persistent Complex Bereavement Disorder, is characterized by a series of symptoms of melancholic type that includes:

"persistent yearning/longing for the deceased (Criterion Bl), which may be associated with intense sorrow and frequent crying (Criterion B2) or preoccupation with the deceased (Criterion B3)" (p. 790) and which has been persistent for more than 12 months among adults and for more than six months in children. When comparing the criterion adopted by Tatossian to differentiate the normal behavior from the pathological one with the criterion proposed by the DSM-5, we can perceive that there is a point of convergence between both. Tatossian (1979/2006) defines as pathological the behavior that is stagnant, crystallized: the behavior that cannot fail to manifest itself. Behavior stagnation is also contemplated in the criterion adopted by the DSM-5 to differentiate the normal from the pathological behavior in the case of mourning, fundamentally delimited by the criterion of chronological time.

What seems to diverge between the two perspectives – alike, at first – is how the time that determines the behavior stagnation is defined. Concerning the DSM-5, this norm is external to the subject, heteronomical, and standardized: 12 months for adults and six for children. According to Tatossian (1979/2006), however, the stagnation or not of a particular behavior is perceived through the very experience of patients, observed by the clinician, within the core of the patients' existence. The pathological character, according to this reasoning, is revealed in the patients' global way of being, in the difficulty that they have (or not) in perceiving their own possibilities (Bloc, 2012). Divergence, therefore, lies in the shift of the perspective proposed by Tatossian, which refuses to perceive the symptom as revealing of a nosological entity exclusively, and which starts to emphasize the phenomenon in its particular mode of presentation.

DSM-5 must be understood from the inferential model that serves as its basis, in which the establishment of criteria and the delimitation of characteristics that define each condition are appropriate. Including or not the diagnosis of Persistent Complex Bereavement Disorder in the upcoming DSM editions, Tatossian's contribution to the reasoning on the issue remains relevant. After all, his perceptual model proposes to consider the diagnostic as a process that comprehends the symptom not as a metaphor, but as *Gestalt*, in such a way we can interpret that the phenomenon in question, whether depression or bereavement, is manifested in the patients' way of being. According to the inferential model, symptoms indicate the phenomenon and, when primarily focusing on them, the clinician loses sight of the very phenomenon of existence. In this sense, we may say that the critical way Tatossian perceives the diagnostic process leads the discussion about the relationship between clinical practice and diagnosis to another level, according to which the clinical practice must prioritize, and not neglect, the lived experience. As highlighted by Bloc (2012), there is no interest in confronting or denying inferential diagnoses, but pushing them to a practice that renews theory day by day, in which the lived experience is always revealed in its singularity in the relationship between patient and clinician.

Following Tatossian's proposal to transform our perspective, we emphasize that "symptoms" of the Persistent Complex Bereavement Disorder are not signs of suffering, of a silent or insidiously concealed mourning, but of bereavement itself. The fact that a bereaved person prepares meals for the loved one who died, or wishes to die to be together with the deceased, concerns an existence that remains conditioned by their usual ways of being intersubjectively with someone who is deeply meaningful to them. However, these modes were disrupted by death and are now unable to be performed and updated as a possibility in that specific relationship. The experience that life has no meaning without the deceased, or the feeling that a part of yourself died or was lost, consists in bereavement itself, which can be experienced, for instance, by a mother who has lost her only child, whose care and education demanded most of her time and made her existence meaningful. Difficulty in engaging in activities, engaging in relationships, or planning the future are not indexes of one experience, but the real experience of mourning of a young widow. These experiences, deemed by the DSM-5 as possible symptoms of a complicated bereavement, must be noted by clinicians as the bereaved global way of being. The perceptual approach aims the ways lived experience, presented is con-*figured* in daily life by its own existential fluidity. That is, such experiences are characterized as the "disorder" or "syndrome" itself; they are not being concealed or are indicated by someone's behavior or experience:

> bereavement is not a nosological entity given *a priori*, but is a phenomenon that distinctly presents itself in mourning suffered, in the modes bereaved expresses his or her suffering, in the lack of meaning that he or she experiences, in his or her pain, in the ambiguity experienced in the presence-absence of the other. (Freitas, 2018, p. 55)

Likewise, it is the phenomenon – and not the symptom – that grounds the clinical practice in which care does not mean a "cure" unaware of the bereaved existence, but seeks the bereaved autonomy before his or her condition of mourning. The parameter for the clinical and the epistemic cut, that judges and determines the illness and the condition of the bereaved, must be the life itself of those who suffer.

As previously noticed, Tatossian (1997/2014) argues that there must be a balance between the modes of positive assistance present in the psychotherapeutic process, but highlights it is essential to maintain at least a minimum level of freedom to the patient, and we must not lose sight of the objective of restoring their autonomy. Bloc (2012) points out that Tatossian does not suggest for clinicians to impose or induce freedom to the patients since freedom is inherent to existence. Clinicians, therefore, must not "impose" this freedom, but facilitate its recognition and performance. The clinical process is disclosed by the patients' possibilities that are at stake and revealed within, conditioned by an anticipatory-liberatory relationship between clinician and bereaved. It is, therefore, with their

presence, more than with intervention techniques, that clinicians remain *along-with* patients and *solicit* whom they are as bereaved, "leaping ahead" their possibilities, not particularly concerned with their symptoms.

In the experience of mourning, it is essential for bereaved people, to some extent, have their autonomy preserved concerning the "management," or tutelage, of their own life. If death precludes the usual way of being-with of the bereaved and precludes the restoration of life as lived before the death of the loved one, it is incoherent to think of mourning as a process to which one must impose a "cure" or a recovery. It is, at first, an opening to the new, before the presence-absent of the other. Although a substitutive-dominant relationship is possible, even if momentarily, it is impossible to impose a return to a previous living condition or to a preprogrammed direction that cannot be achieved. In other words, what we emphasize is the incoherence of proposing that the resolution of bereavement is achieved through the reestablishment of life as lived before the loss, something that would only become possible with the concrete return of the one who died. However, recovery is often attempted by therapies that impose tasks that do not make sense to the bereaved and their significations of the world. Such overcome being impossible; we emphasize that resignifying bereavement implies respecting the new condition of the bereaved, in which new possibilities of being manifest themselves and are evidenced precisely by the absence-presence of the one who died (Freitas, 2018; Freitas et al., 2015). When resignifying the relationship with the deceased, the conditions imposed by the abrupt suppression of this other in the life of the bereaved are respected, allowing them to incorporate, in their new life-world, the presence-absence of those who are gone.

Bereaved people are placed before the lack of meanings of the world-life, at the same time; they experience the openness to new meanings and new ways of perceiving and experiencing the world. The clinical process makes explicit the opening of possibilities of new meanings for the being-with, maintaining the presence of those who were lost – no longer as intercorporeity – but by the very condition of absence, incorporated in the new way of being of those who are mourning. After all, the relationship between the bereaved and the deceased has the meaning gave by those who experienced it, which leads us to understand that the resignification of this relationship can never be achieved in a heteronomical way (Freitas, 2018). Here we highlight the relevance of the anticipatory-liberatory assistance in the psychotherapeutic process of bereaved people. Its relevance lays in the way this mode of care can help those who suffer to become lucid of their helplessness before the lack of meaning revealed by death, of their possibilities and limitations when facing the end, allowing their autonomy and singularity before the experienced lack of meaning.

Final considerations

Tatossian (1997/2014), when proposing a conversion of the clinical perspective on pathologies and their modes of presentation, leads the discussion about pathology and normality beyond the diagnostic manuals, considering the freedom-unfreedom dyad as a criterion to determine the character of the diagnosis, and no longer exclusively the nosological understanding of the issue. Thus, the psychiatrist makes the recovery of autonomy the main objective of the work and restores the patient in the role of the main agent of this process.

In the case of bereaved, it becomes evident the relevance of a clinical project focused on the experience and on making patients aware of their possibilities and constraints. Nevertheless, the task of resignification can only be given to those who carry in the still-living flesh a relationship that imposes itself as suspension and lack of meanings due to the irreversibility of death. Thus, approaching the thought of Tatossian from a phenomenological understanding of bereavement, we highlight a clinical practice that respects the specificities of the global way of being of each bereaved, and which seeks the improvement of their autonomy when dealing with their new condition. However, this research does not end the discussion about the possible inclusion of the Persistent Complex Bereavement Disorder diagnosis in upcoming DSM editions. In this sense, more studies by researchers and clinicians on the issue remain necessary.

A clínica do luto e seus critérios diagnósticos: possíveis contribuições de Tatossian

Resumo: O *Manual diagnóstico e estatístico de transtornos mentais* (DSM-5) avulta a discussão do problema da diferenciação entre luto normal e complicado. Tendo por fundamento a obra de Arthur Tatossian e uma perspectiva fenomenológica do luto, temos como objetivo problematizar a clínica do luto em seu entrelaçamento com a compreensão diagnóstica. Apresenta-se a concepção de que o luto é vivido como um fenômeno intersubjetivo e como experiência de perda de um mundo partilhado que se rompe com a morte. Ao se perder um ente querido, perdem-se também uma perspectiva e uma possibilidade existencial, cabendo ao enlutado a ressignificação de seu existir, e não o retorno a uma vida anterior. A partir da proposição de atenção substituinte-dominante e antecipante-liberante de Tatossian, propõe-se que uma clínica do luto deva considerar a díade liberdade e não liberdade do paciente como critério para a compreensão de sua dimensão patológica e para a tutela do enlutado sobre o seu existir.

Palavras-chave: luto, clínica, psicoterapia, Tatossian.

La clinique du deuil et ses critères diagnostiques : contributions possibles de Tatossian

Résumé : Le DSM-5 étandre la discussion sur le problème de la différenciation entre le deuil normal et compliqué. Sur la base des travaux du Tatossian et dans une perspective phénoménologique du deuil, notre objectif est de problématiser la clinique du deuil et ses relations avec le processus diagnostique. Nous présentons la conception selon laquelle le deuil est vécu comme un phénomène intersubjectif et comme perte d'un monde partagé, perturbé par la mort. Lorsque on perde un être cher, on perd également une perspective et une possibilité existentielle, où l'endeuillé est laissé avec le besoin du signifier son existence et pas de retourner à une vie antérieure. Sur la base de la proposition de types de soins devançant-libérant et substituant-dominante de Tatossian, on propose qu'une clinique du deuil doit considérer la dyade liberté et non-liberté du patient comme critère de compréhension de sa dimension pathologique et de la tutelle d'endeuillé sur son existence.

Mots-clés : deuil, clinique, psychotherapie, Tatossian.

La clínica del duelo y sus criterios diagnósticos: posibles contribuciones de Tatossian

Resumen: El DSM-5 amplia la discusión del problema de la diferenciación entre el duelo normal y el complicado. Fundamentado en la obra de Arthur Tatossian y en una perspectiva fenomenológica del luto, nosotros tenemos como objetivo problematizar la clínica del duelo en su entrelazamiento con suja comprensión diagnóstica. Presentamos la concepción de que el luto es vivido como un fenómeno intersubjetivo y como experiencia de pérdida de un mundo compartido fracturado por la muerte. Al perderse un ente querido, se pierde también una perspectiva y una posibilidad existencial, cabiendo al enlutado la resignificación de su existir y no el retorno a una vida anterior. A partir de la proposición de atención sustitutiva-dominante y anticipante-liberadora de Tatossian, se propone que una clínica del duelo deba considerar la díada libertad y no libertad del paciente, como criterio para la comprensión de su dimensión patológica y para la tutela del enlutado sobre su existencia.

Palabras clave: duelo, clínica, psicoterapia, Tatossian.

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